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Clinician's Perspectives on Physical Holds: The Impact on Adolescents with Abuse History

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Clinician's Perspectives on Physical Holds: The Impact on Adolescents with Abuse History

by

Keeli N. Wagner, BSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the University Institutional Review Board, Implement the project and publicly present the findings of the study. This project is neither a Master's Thesis nor a dissertation.

CLINICIAN'S PERSPECTIVES ON PHYSICAL HOLDS

Abstract

Recently, the use of physical holds or physical restraints on adolescents in residential and psychiatric treatment facilities has become a rising controversy among the professionals working in these settings. The literature discusses the debate more in detail, touching on the potential psychological risks associated with these holds and whether or not this outweighs the need to perform these holds to ensure safety for these adolescents. This research was designed to study this controversy in more detail, specifically examining the effects of physical holds on adolescents with a history of abuse through the experiences and perceptions of the clinicians who have witnessed or performed these holds. This study used qualitative research, which included data collection and analysis using content analysis to establish themes within the data. This data was collected from 8 clinicians who currently work in a residential treatment setting and have witnessed or performed physical holds on those with an abuse history. The following themes were identified from the data; a) ensuring safety, b) importance of training, c) trauma response, d) importance of processing physical holds, e) loss of power and control, f) secondary trauma and g) trauma or abuse history. The findings of this study have many implications that will be relevant to various professionals working with children or adolescents. Possibly the most important indication is the potential to significantly reduce the adverse effects of physical holds and transition towards utilizing holds as a therapeutic tool to further help clients experience change.

Keywords: physical holds, physical restraints, adolescents, clinician's perspectives, history of abuse, ensuring safety

CLINICIAN'S PERSPECTIVES ON PHYSICAL HOLDS

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Clinician's Perspectives on Physical Holds: The Impact on Adolescents with Abuse History

“As the behavior problems of children entering residential care have become increasingly difficult to manage, the use of interventions involving physical restraint, pharmacological restraint, time out and seclusion in many care settings has increased as well (Jones & Timbers, 2003).” There are many thoughtful arguments in favor of the use of physical restraints as therapeutic interventions; however they have more recently been surpassed by the negative press related to the injuries and deaths that have resulted from restraints as well (Jones & Timbers, 2003). As a result of some of this negative press, physical holds or restraints are now being looked at and researched by professionals working in this field, in order to further analyze the affects these holds may be having on the populations they are being utilized with. Authors Davidson, McCullough, Steckley & Warren (2012) state that a “*Physical Hold* or *Physical Restraint*” refers to a type of intervention in which staff physically holds a child to restrict their movement in order to prevent harm to themselves or others (as cited in Steckley, 2010). For the purpose of this paper, physical hold and physical restraint will be used as the same concept. In regards to the use of physical restraints on adolescents, there are different training programs throughout the United States, many of which use various types of restraints. The different types of restraints that are used within psychiatric facilities will be expanded on later in this paper.

Ongoing concern about the use of physical holds has led to professionals taking a more in depth look at the affects physical holds may have on children and adolescents who have experienced abuse. Author Ruth Gallop (1999), states “It is the fundamental

moral responsibility of health professionals to do no harm” (p.413). Therefore, it is part of a social workers’ obligation to be familiar with the issues of abuse, the signs and symptoms to look for to identify abuse, as well as what resources and interventions are available to adolescents experiencing some type of abuse.

More recently, physical holds or restraints have been surfacing as one of the most traumatizing things for a child who has a history of being abused. An article titled “*The Relationship between Seclusion and Restraint Use and Childhood Abuse among Psychiatric Inpatients* (Hammer, Springer, Beck, Menditto, & Coleman, 2011), reports that the use of seclusion and restraint interventions is a debated topic in the mental health field due to the likelihood of childhood abuse being found among clients. The controversy exists because researchers argue that physical holds are often needed to ensure safety but in exchange, can often have positive therapeutic effects for the child as well (Zeigler, 2004). It is important for clinicians to recognize this so they can remain aware of whether or not the interventions being used in their treatment setting are therapeutic.

If it is found that these interventions are in fact harmful to these children or adolescents, there may be more effective practices and interventions that clinicians can learn that may still keep the child safe, ensure stability as well as prevent any further harm to the child.

Research has also shown that performing physical holds on adolescents can cause secondary trauma to the clinicians performing or witnessing the holds. Many studies show that clinicians performing the holds have an overall negative feeling regarding the holds and report they can cause the clinician to feel uncomfortable or become physically

and emotionally distressed (Steckley, 2012). This is important to explore further so that the profession is aware of the best practices available for not only the child but also the clinicians involved in the practice.

The primary purpose of this paper is to examine the impact physical holds may be having on adolescents with a history of abuse through the perspective of the clinicians who are witnessing or performing the physical holds. In regards to the use of the term "Clinicians" within this research study, this term is being utilized to describe a wide range of disciplines that may be working with this population including, social workers, mental health professionals, psychiatrists, psychologists and residential staff. This research will seek to answer the following research questions: 1) What are the experiences of clinicians in witnessing and performing physical holds on children with a history of abuse? and 2) What is the clinician's perception of how this adolescent population is affected by physical holds? This study seeks to inform professionals on how these interventions are affecting the adolescents involved in these holds, as well as what other types of interventions could be incorporated into treatment models in order to better serve these clients. This research will contribute to the learning of the professionals working with adolescents in residential and psychiatric treatment facilities that are implementing physical hold interventions.

Literature Review

Physical Holds

Many professionals are experiencing a dispute over the practice of physical restraints or physical holds in hospitals and treatment facilities due to the effects they may have on the clients and the adults performing these interventions. Physical holds are

a type of intervention used most frequently in residential treatment and psychiatric inpatient facilities. These types of interventions are intended to be used by a trained professional in situations in which it is necessary to protect a child from harming themselves or others (Zeigler, 2004).

Types. The Minnesota Department of Education identifies “physical restraint, termed “physical holding” in relevant Minnesota law, generally includes several different types of physical holds (Pust, 2012, p.4).” According to an article on the use of restraints in schools, “The majority of crisis intervention programs provide training on physical holds in one or more of the following areas: (a) protection and release, (b) physical escorts, (c) standing restraints, (d) seated restraints, and (e) prone floor restraints (Couvillon, Peterson, Ryan, Scheuermann, and Stegall, 2010, p. 6).” The most common types of holds used with children and adolescents are; escort holds, standing holds and prone holds (see Figure 1.1) (Couvillon, et. al., 2010). Other common types of physical holds include basket holds (see Figure 1.2) and supine holds (see Figure 1.3) (Pust, 2012). Physical escorts are a type of restraint used to “transport a child from one setting to another for purposes of safety (Couvillon, et al., 2010, p.7).” These holds are done by two staff members holding each one of the child’s arms by the wrist and elbow, guiding them to a place determined to be safe for the child and others. Standing restraints are a type of restraint used to “immobilize a child from a standing position” and prone restraints are used to hold a child “face down, supine or on their side” on the floor for safety purposes (Couvillon et al, 2010, p.7).” Again, there are various ways in which to carry out each of these methods, however standing restraints are typically done by holding a child up against the corner of a wall, with their face pointing into the corner and

a staff member on either side of them, holding their arms out flat against the adjoining walls. Prone holds are typically performed by placing a child face down on the floor with staff members holding their arms and legs flat to the floor. Physical escorts are considered least restrictive, and prone most restrictive, with standing restraints in the middle as a method used in between if needed. These physical restraints are utilized primarily in residential and psychiatric in-patient settings with children and adolescents who are in danger of harming themselves or those around them (Couvillon et al., 2010).

Controversy. The use of physical restraints has become a controversial issue due to some of the information surfacing on the potential negative effects they may have on the children being held as well as those witnessing the hold. Some of the research is addressing a number of client deaths, injuries and psychological trauma that have resulted from the use of these interventions (Mullen, 2000; Mohr, 2006). Therefore, many facilities are searching for new ways to conduct physical holds or alternative methods of treatment for the children residing in these settings (Hammer et al., 2011). According to Lorraine Fox (2004), "One way to reduce the amount of physical restraints in a treatment program is to encourage staff to view restraint from the client's point of view (p.1)." This same idea is spreading to hospitals and treatment facilities in the hopes of finding alternative methods of treatment. Other researchers are arguing that physical holds may be therapeutic to children and that these types of interventions are often the only option to ensure safety of the child and those around them (Zeigler, 2004). Some clinicians believe that physical holds allow children to see that adults are able to keep them safe and control the environment around them, as well as provide them with a type of therapeutic physical touch (Zeigler, 2004). Due to this controversy and the dangers of using physical holds as

methods of intervention, many professionals are hoping to determine if physical holds are the best option for children with emotional and behavioral disturbances or if there are alternative methods that may be more affective.

Negative Effects of Holds

Re-Traumatization. The negative impact physical holds may have on children, particularly those who have been abused is documented well in the literature, although most of the studies conducted on this idea are quite recent (Bullard, Fulmore & Johnson, 2003; Crosland et al., 2008; Fox, 2004). The idea of physical interventions has been studied for quite some time but the most recent literature is focusing more specifically on the negative impact physical holds are having on children with a history of abuse or trauma and the dangers that result from doing such holds on already violent and troubled children (Hammer et al., 2011). Regardless of when or how the abuse might have occurred, most children are forever affected by the abuse they have experienced (Clarke, Grant-Knight, Koenen & MacDonald, 1998). They often experience intrusive memories, repetitive play, flashbacks or nightmares, dissociative episodes, trouble sleeping, hyperactivity and other symptoms that are often diagnosed as Post Traumatic Stress Disorder (PTSD) (DSM-5, 2013).

These children are very vulnerable, especially when they are young or when the abuse is recent. Many things can trigger a flashback or physical symptoms that are associated with the abuse they experienced (Dyregrov & Yule, 2006). Children who have been physically or sexually abused in the past may experience re-traumatization from physical holds (Zeigler, 2004). The trauma-informed care perspective suggests that the use of seclusion and restraint with previously abused children may result in a form of

re-traumatization due to the child associating the physical hold with the experience of past abuse (Hammer et al., 2011). Author Lorraine Fox (2004), refers to four stress responses that can occur when a child is re-experiencing their trauma: “intense fear, helplessness, horror, and mental disorganization.” These types of responses can often be experienced during a physical hold when a child may be re-experiencing their past abuse. Many children may feel the same feelings they felt when they were being abused due to the intensity of the physical hold process. An article on this controversy also discusses the possibility of clinicians becoming agitated or angry during a hold, and therefore if the physical restraint is done in a way that the child feels is too violent or dangerous it may replicate some of their past abuse (Zeigler, 2004).

Death. Even greater than the psychological injury these children may experience is the risk of great bodily harm or even death. Consequently, deaths and serious injury to children and the adults doing the holds is also one of the topics of controversy surrounding this issue (Nunno, Holden & Tollar, 2006). The most common restraint-related death is asphyxiation. This can occur when a person's body position interferes with their breathing. When placed in a physical hold, the position that most often results in asphyxiation is the prone position. Due to a child's small size and weight, when in a prone hold, asphyxiation can occur more rapidly than it would in someone of larger size (Nunno et al., 2006). Serious injuries to staff and the child can also occur including bite marks, broken bones, and transmission of illness through saliva or bodily fluids. This is a risk that is possible every time a physical hold is conducted. Some clinicians argue that these risks outweigh need for the physical hold to be implemented at all.

Training

Several studies also focus on the potential lack of training that professionals may have on how to effectively perform a hold on an escalated child, as well as the importance of adequate training and supervision. (Crosland et al, 2008 & Bullard et al., 2003)

Clinicians who are in charge of doing physical holds on children may not be adequately trained on how or when a physical hold is appropriate. Professionals also may not be trained in the right techniques to use in order to complete a hold safely according to each child's personal needs (Fox, 2004). Clinicians may be unable to relate to the child or understand the child's particular needs; therefore they immediately assume a child needs to be held and may perform holds on children when it may not be necessary (Fox, 2004).

Some clinicians studying this controversy suggest that along with training on how to perform holds, alternative methods of de-escalation should also be taught and stressed within treatment facilities (Gallop & McCay, 1999). These professionals feel that treatment techniques should be tailored for each specific child so that the techniques being used make sense for each child's situation or behaviors. Along with alternate techniques, staff should also be trained how to accurately perform a physical hold on a child (Gallop et al., 1999). One study indicates that greater staff competency is linked to fewer injuries as a result of physical holds (Bullard et al., 2003). Not only should staff be trained on how to complete physical holds, but the techniques being taught and used should be adequately tested to help prevent injuries and death. According to Dave Ziegler (2004), physical interventions that are allowed to be used in treatment settings have been extensively tested to ensure they are being carried out in accordance with national

guidelines. Therefore, treatment facilities need to ensure that they are teaching the techniques that are in accordance with these guidelines and have been approved for use on children.

Harm to Professionals

Emotional. In addition to physical and emotional harm to the children experiencing the holds, research has shown that there is also the potential for physical and emotional harm to the professionals performing the holds (Steckley & Kendrick, 2008; Steckley, 2012). In numerous research articles, the staff consistently report that the experience of restraint comes with many negative and uncomfortable emotions (Steckley & Kendrick, 2008; Steckley, 2012). One article displays many staff members different reactions to the restraint experience, with various staff members stating the experience was horrific, discouraging, uncomfortable or full of guilt (Steckley and Kendrick, 2008). The research also shows responses from professionals of sadness, guilt, and fear. Due to so many physical injuries resulting from physical holds, many staff members are also afraid of doing serious harm to the child. Authors Steckley and Kendrick (2008), also state that many staff struggle with “overriding emotions of guilt, doubt or defeat at not being able to avoid the physical restraint (pg.562).” Along with these emotions, there is a potential for the professional to experience secondary trauma, depending on the severity of the hold or the behavior that the child displays before or during the hold.

Physical. There is also potential for physical injury to the staff member during the hold, including being hit, kicked, spit on, bit or several other injuries depending on the severity of the child's behavior. Often, children in holds become very aggressive, especially if experiencing some type of flashback or re-traumatization (Steckley, 2012).

This puts professionals at significant risk for physical injury in the midst of attempting to keep a child safe. This is concerning because if a professional becomes injured during a restraint and is unable to continue the restraint, this may put the child or those around them at risk of further harm as well. The potential risk for professionals associated with physical holds is another reason clinicians are looking towards alternative methods of intervention that may be more appropriate.

Positive Effects of Holds

Physical touch and the opportunity to express real emotions are a few things that can be very therapeutic for a child in crisis. Often, children who are acting out in such extreme, violent ways are feeling as though they are in a life or death situation, therefore simple touch can be very calming and reassuring for a child in this state (Zeigler, 2004). Children also need reassurance that adults are in charge and are able to ensure their safety. For many children who've been abused or neglected this is something they have never experienced before. Physical holds can help a child understand that they don't have to be in control at all times and that adults will take care of them (Zeigler, 2004). For children who have issues with behavior control and who do not know how to express their needs, firm and safe physical touch can be exactly what they need in a time of crisis. This is also an opportunity for these children to express emotions or feelings that they might not otherwise feel safe disclosing (Zeigler, 2004). Through physical holds and therapeutic touch, traumatized children are also able to learn that not all touch ends in being abused or harmed in some way. "Supportive Physical Restraints" allow us to retrain a child's body to understand they do not have to fear touch from other people (Zeigler, 2004).

Overall, safety for this population is most important and physical restraint is the surest way to prevent injury or significant harm. Author Dave Zeigler states “Restraint and Seclusion, when used properly, can be lifesaving and injury sparing interventions (2004).” This population often has difficulty with self-control and is at risk for placing themselves or others at risk, therefore physical holds are often needed in order to ensure the safety of everyone involved. All of these things are just some of the positive, therapeutic effects that can come out of a physical hold. For this reason, the controversy over whether or not physical holds are effective techniques to be used within treatment facilities is still active in the literature.

Alternative Interventions

In addition to the potential positive effects that physical holds may have on children, practitioners are discussing the option for alternative interventions. Professionals working at treatment facilities need to be trained in different techniques to help a child de-escalate and control their behavior (Bullard, 2003). Evidence shows that restraints and seclusion can be reduced by encouraging staff members to find alternative methods to de-escalate clients that may be at risk of needing physical restraint (Bullard, 2003). De-escalation techniques that can be used instead of physical holds include the following: prompting, using active listening, problem solving, conflict resolution, redirection, and directive statements, among many others (Bullard, 2003). An article on women in psychiatric hospitalizations suggests that alternative methods such as, observation, support, medications and alternative ways for the individual to act out aggression are all constructive methods that may prevent the individual from escalating to a point in which a physical restraint will be needed (Gallop et al., 1999). Assisting a child

or adolescent in learning to regulate their emotions and using basic de-escalation techniques is what is emerging as alternatives to physical holds. Clinicians feel that the more personalized these techniques can be to each child, the more likely they are to be affective (Gallop et al., 1999).

Although research on physical interventions has been conducted in the past, the correlation between traumatized children and physical hold interventions is newly emerging. Children experience unique psychological effects from physical intervention techniques. It has been shown that children who have been abused or neglected often experience re-traumatization when placed in a physical hold (Fox, 2004). In addition to the effects these techniques have on children, there are several other controversies that exist over these intervention techniques. For example, the lack of staff training on how and when to physically hold a child as well as the lack of understanding or empathy staff may have for the emotions the child is experiencing before, during and after a physical hold is concerning (Crosland et al, 2008; Fox, 2004).

Considering the magnitude of controversies that exist over these techniques, it is apparent that more studies need to be done in order to really provide accurate information to professionals on how these techniques affect the children and the staff. Considering all of these variables and addressing them as intensively as possible will provide more accurate information for treatment facilities and help professionals better resolve these issues.

Conceptual Framework

Systems Theory

This study will be based off the conceptual frameworks of Systems Theory and attachment theory in social work practice. Systems Theory “focuses attention not only on the organism but also on the environment. It also reflects a returning awareness of the interrelatedness of individual problems with larger social structure failures (Leighninger, 1977, p. 45).” This theory allows social work practice to look at how the systematic problems may be failing to assist the individual in moving towards success. The children within residential and psychiatric facilities are part of numerous social systems including peer groups, the medical model, overarching regulatory systems and agencies in which stabilization and behavior modification are of primary focus.

The clinicians working within these settings to assist children with a history of abuse are working with a variety of systems that are informing their practice, on both a micro and macro level. Social Workers and clinicians in these settings must be aware of how these systems are impacting their ability to effectively help their clients and how the systems themselves may be influencing their client's daily behavior. Directly related to the practice of physical holds, there may be macro level systems that are regulating this practice method and may be causing further difficulty for both the child and the clinician.

Attachment Theory

Attachment, whether securely formed or disorganized, is a vital part of every person. Everyone has an attachment and according to Dan Siegel (1999), a leader in attachment theory, “Attachment relationships create the central foundation from which the mind develops (p. 142).” Depending on the type of attachment that a child has formed, it can affect the way they are able to form relationships with others, their sense of self and their ability to regulate their own emotions. Children with a history of abuse and

trauma very often have an insecure or disorganized attachment which can lead to confusing behaviors that are difficult to manage. According to Erik Hesse and Mary Main (2000), "Disorganized attachment predicts disruptive, aggressive and dissociative behaviors in childhood and adolescence (p.54)." That being said, many children in residential and psychiatric treatment facilities display these types of behaviors and these are often the types of behaviors that lead to physical holds.

Helping children who have not been able to develop secure attachment relationships overcome some of the difficulties this may cause with behavior and emotion regulation is a vital part of the social work role. The attachment relationship that each child has already formed with their caregivers can affect the relationship they form with the staff or professionals they are working with as well. The relationship between the adolescent and staff member has the potential to significantly affect the hold experience for each individual involved as well. The conceptual framework of attachment relationships will help inform this study and assist in identifying the ways that attachment might inform the effects that physical holds have on adolescents as well as the clinicians performing the holds.

These two conceptual frameworks will assist in informing this research by looking at the various systems that may be influencing social work practice among residential and other psychiatric settings. This study will examine how these systems may be affecting the clinician's ability to effectively employ alternative methods of treatment for children with a history of abuse. The attachment relationships that are formed between the clinician and child will also be analyzed to determine if their relationship may effect how the physical hold is perceived by each individual. Both of these

conceptual frameworks will assist in informing this research to determine the clinician's experiences and effects of physical holds on adolescents with a history of abuse.

Methods

Research Design

This is a qualitative study in which participants were asked questions designed to provoke responses that share the clinicians' perspectives on witnessing and performing physical holds on adolescents with a history of abuse. Qualitative research seeks to discover the "meanings, concepts, definitions, characteristics, metaphors, symbols and description of things," rather than the numbers or measures of certain things (Berg, 2012, pg. 3). Qualitative research is a form of research that can be used to understand people's lives and the meanings people give to certain events or experiences (Berg, 2012). Through qualitative research, this study can provide future social workers with a greater understanding of what it may be like to witness or perform physical holds on adolescents with a history of abuse.

Qualitative research was most appropriate for this study because participants were asked open-ended questions in which they were able to fully express their opinions and experiences about the topic. The questions being asked focused specifically on their involvement with adolescents who have a history of abuse and what impact physical holds may be having on this population. The data collected was analyzed for a collection of participant's experiences rather than a collection of numbers or facts. This study has obtained first-hand experience from clinicians who have witnessed or performed physical holds. This study's goal was also to understand clinician's perceptions on how physical holds may be affecting this population.

Sample

This study included a convenience sample of 8 participants from four different sub-agencies within a larger organization. These agencies are a set of four residential treatment programs for adolescents with emotional and behavioral disorders. The research included a convenience, snowball sample due to the researcher having a relationship with an employee within one of these agencies. This employee assisted in sending out an agency wide email to all potential clinicians within each of the three agencies that met the qualifications for participating in this study. This email included an informational sheet with the details of the study and invited them to participate in an in-person or written interview through email (See Appendix B). Participants could have been recruited by phone as needed (See Appendix D). It was required that participants have had experience working with adolescents who have a history of abuse. Participants were also required to have had witnessed or performed physical holds on these adolescents.

The program director from each agency gave permission, through a written letter of cooperation (See Appendix E), for this researcher to contact staff within their individual agencies through email or phone to recruit participants for this study. This researcher utilized personal contacts within the agency to recruit participants through an informational email on what is involved with this study or by phone as needed.

Protection of Human Subjects

Participants in this research were asked to read over and sign a consent form (See Appendix C) that was reviewed by St. Catherine University's Institutional Review Board prior to participating in the interview. Their participation in the study was voluntary and

there was no direct benefits offered to the participants. The consent form was sent to participants via email prior to the interview so they could review it and ask any questions they had. A copy of the interview questions (See Appendix A) were also emailed to the participants ahead of time for review. The participants were offered a paper copy of the consent form to keep for their records.

There were no direct risks to the participants and their personal information was kept confidential. Participants were asked to answer 10 questions directly related to their experiences with the population being studied as well as their experience in witnessing or performing physical holds. Each interview was approximately 45 minutes to one hour. Participants had the option to complete the interview in person or through password protected email correspondence. Participants were also asked to consent to an audio-taping of the interview if it occurred in person or on the phone and to allow the information to be reviewed by and presented to this researcher's advisor in a non-identifying way. While the research was being conducted, audio tapes and documents containing personal information of participants were kept in a locked filing cabinet in the researcher's home. Upon completion of the data analysis portion of the research project, all documents and audio tapes containing participants' personal information were destroyed. Interviews that took place through email were done through a password protected email connection and any identifying information about the participant was blocked out when presented to this researcher's advisor for review. Participants were informed of the measures being taken to protect confidentiality before completing the interview. A list of several different mental health resources (See Appendix F) was also

provided to participants upon completion of the interview in case they felt they needed to seek additional support on the information being discussed.

Data Collection

The interview guide was in a semi-structured format, guided by a set of questions that were pre-approved by Dr. Catherine Marrs Fuchsel as required by the IRB. The questions were developed as accurately and open-ended as possible to maintain the reliability of the research and to help encourage honest feedback that is not led by the interviewer. The interview questions were based on ideas that were developed from the literature as well as questions that the researcher established based on her own experience with residential settings, adolescents with abuse history and conducting physical holds. Any in- person or phone interviews were audio-taped and transcribed after completion of the interview. Interviews conducted through email were printed and transcribed as well. Content analysis was conducted of all interviews, looking for patterns and themes in the participants responses. Content analysis consists of a “systematic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases and meanings (Berg, 2012, p. 349). The identified patterns or themes found in the transcripts were then be used to help address the research questions of the study.

Strengths & Limitations

This study offers several strengths. First, the questions being asked were formed directly from the literature and the researcher's experience with physical holds. The questions were intending to gain first-hand experience from the clinicians being interviewed. The information gathered from this study helped to support current social work practices by identifying areas of strength as well as other areas that may need to be

improved upon. This study was explored from the perspective of those clinicians currently working with the population being studied. It has addressed the lack of current research on this topic as well as the lack of research from a clinician's perspective. Last, this study was conducted in a qualitative manner, therefore designed to provide a more comprehensive and detailed account of the clinician's experiences.

This study also has a few limitations. First, it was conducted within a short time period and with a small sample size. This study also relied on the availability of the participants and the first available clinician. Second, the participants were only asked 10 questions during the interview process, again due to the time constraints of the project. Last, the participants were all selected from agencies that are within the same larger company and no participants from other companies were pursued. Therefore, the sample only offered limited diversity in respect to various agency perspectives. In spite of these limitations, this study is still relevant and important to the social work field.

This researcher has personal experience witnessing and conducting physical holds which may have acted as a strength and limitation of this study. The researcher's experience has led to certain beliefs or biases about physical holds and the effects they may have on adolescents. Therefore, this researcher may have been more critical or biased when conducting the research or reviewing the data. This would be a limitation to this study. However, given the researcher's pre-conceived opinions and biases, this researcher was also more critical of the data in hopes of finding information that may contradict the researcher's viewpoint. Therefore, the researcher may have worked more diligently to ensure that all the data and findings were accurately recorded and represented.

Conclusion

This study was conducted in a qualitative manner that seeks to gain the perspectives of clinicians in regards to their experiences with physical holds and their effects on children with a history of abuse. This study was conducted through interviews with 8 participants who have work related experience in working with children and adolescents and performing physical holds. This study is particularly important to the field of social work in order to provide further research on the controversial topic of physical holds being performed on children, specifically those with a history of abuse. The research aims to inform clinicians of the continued benefits of this practice as well as the possible consequences of continuing to perform physical holds on this population. This research also attempted to identify alternative interventions on the practice of physical holds.

Findings

The purpose of these interviews was to further understand the clinician's perspectives of the effects of physical holds on adolescents with a history of abuse. These findings include the demographics of the participants involved in this study as well as seven emerging themes identified from the participant's responses through coding and analysis. In order to protect the participant's identities and maintain confidentiality, they will be referred to individually as Participants 1-8. These participants reported on their experience and training with physical holds, their perceptions on the effects of the physical holds, their opinions on alternative interventions and if they feel physical holds can be avoided. Content analysis and word counting was conducted to identify emerging

themes within the data. The primary themes identified are as follows: a) ensuring safety, b) importance of training, c) trauma response, d) importance of processing physical holds, e) loss of power and control, f) secondary trauma and g) trauma or abuse history.

Demographics

Participants included eight different professionals who are currently working within residential treatment centers in Minnesota. Some of the participants were social workers, licensed therapists, and residential staff members with other types of undergraduate degrees. All eight participants were middle-aged females, over the age of 18. Two respondents hold a master's degree and the other six hold some type of bachelor's degree. Respondents 1 -5 and Respondent 7 all hold bachelor's degrees and have worked in residential settings for 2-5 years. Respondents 6 and 8 hold master's degrees and have worked in residential settings for 7-16 years. Each participant has had experience witnessing or performing physical holds on adolescents. All respondents reported that the majority of the youth they worked with have experienced abuse or trauma in their past. The largest theme that was found throughout the research was ensuring safety. Safety for the adolescent, staff and others was discussed frequently by all participants as the leading reason to perform a physical hold.

Ensuring Safety

Participants were asked several questions related to their experience and training on performing physical holds on adolescents. Throughout these questions participants continued to address the importance of safety for the adolescent involved in the hold, the staff and other people that were around during the event. Participants reported that

performing holds is often necessary in order to ensure safety. Participants were asked “What is your experience in performing physical holds on children or adolescents?”

Participant 3 responded, “I was required to perform physical holds on adolescents if they became a harm to themselves or others.”

Participant 4 responded:

I performed physical holds on children ages 13-18 years old. These holds ranged from simple escorts with just arms and walking, to having to place a girl in a hold in which she was held to the ground for her safety or the safety of others.

Participants were also asked, “What has your personal experience or reaction been when witnessing or performing a physical hold on an adolescent with a history of abuse?” Participants reported on their experiences in regards to physical holds. For example, participant 4 stated, “For me, doing a physical hold is necessary when a child can no longer be safe to themselves or for others and not just because they are doing a negative behavior.”

Participant 6 responded:

I have only been in one hold where the adolescent experienced a flashback. In the moment it was difficult, because I wanted to release my hold on the resident due to their statements indicating she was having a flashback. Initially we did release the hold and she again attempted to run while making suicidal comments so we did the hold again for safety purposes. I was able to process afterwards and be okay. I think because the hold was warranted and for safety purposes I was able to be fine professionally.

Participant 7 responded, "I don't agree with not doing restrictive procedures ever-safety has to come first and sometimes that's the only option."

Participant 2 stated:

I performed physical holds often in the first few years of being a residential counselor. Doing physical restraints was not a comfortable thing and often this was the part of my job that caused the most stress on me. I was able to validate myself and my co-workers during this because we were doing physical restraints in order to keep our residents safe.

In order to determine if the participants felt that the holds they performed could be avoided, participants were asked, "The literature on physical holds states that if professionals were better trained on how to relate to the child or adolescent and understand their particular needs during escalation, and physical holds could be avoided. What are your thoughts on this statement?"

Participant 2 responded, "I think having a good and understanding relationship with the adolescent you are working with makes a big difference but I also think that there are some situations where for the safety of all involved, a physical restraint needs to be used."

Participant 6 responded:

The only time we really have to use physical holds is when a resident is expressing suicidal ideation and attempting to run from our program. We are not a locked placement and if this situation occurs more than once we then refer the resident to a more secure program because they are unable to use their environment for safety. I do not think physical holds can be entirely avoided.

Residents in residential treatment are mentally unwell and display very unsafe behaviors.

Respondent 7 stated:

It can really help the situation if you understand the kid, and can calm them down or address what's driving their behavior. However, sometimes they want to do and they don't care if they have to hurt people to do it. The hold I was involved in came about because a girl was trying to hang herself and had beaten up 2 of my coworkers who were trying to stop her. In that situation, there was literally no other way to keep her safe.

In order for staff members and other professionals to ensure safety for these individuals, respondents reported on the importance of training in recognizing signs of escalation and how to properly conduct physical holds.

Importance of Training

After being asked about the amount and type of training the clinicians received surrounding performing physical holds and if they felt the training was enough for them to feel comfortable performing holds on children without causing harm, a common theme among the participants was the importance of the training they received. The majority of the participants felt that the training they received was adequate and they felt prepared to perform holds without causing harm to the child or adolescent. Most of the participants reported "regular" training on an annual basis, at minimum and most all participants identified the training as "hands on" which helped the participants feel more confident in their abilities. Participants also identified different techniques they were taught in order to help them try to prevent holds.

Participant 2 stated:

I felt my training was beneficial and adequate. There was training on the actual physical holds as well as training on de-escalation and calming techniques. I felt that it was very helpful to have the de-escalation techniques as part of this training in order to help fully understand the need and human aspects of physical holds.

Participant 3 also reported on being taught a “continuum of force” so that the clinicians could be sure to match their level of force with the adolescent’s behavior. This participant also reported being trained on “why holds were performed, when to utilize them, ways to avoid them and what it was like to go through them.”

Although most participants acknowledged feeling their training was adequate, there were a few participants who felt it was not. Participant 3 states “I did not feel like I was given adequate training on performing physical holds without causing harm because I always felt like we were causing [them] further trauma or harm by having to hold them down.”

Participant 7 also stated she did not feel her training was adequate and states, “I think it’s something you need to do enough times so that you can do it correctly without having to think about it, and the residents aren’t the ones I want to practice on!”

Participants indicated that their training and experience helped prepare them to perform physical holds without fear of causing further physical harm. However, participants indicated that regardless of the amount of training they received, they often felt adolescents experienced a trauma response that was triggered by the physical hold.

Trauma Response

One of the most controversial discussions surrounding physical holds is the question of whether or not holds cause further trauma to the children and adolescents they are conducted upon. When asked, “ In your experience , does performing physical holds on adolescents cause further trauma to those who already have a history of abuse,” participants indicated that they felt holds have the potential to cause further trauma as well as trigger a trauma response of some kind while the hold is being conducted. The majority of participants indicated that they felt they witnessed a “trauma response” in the adolescents evidenced by them dissociating, having a flashback or other physical and behavioral symptoms. Several participants reported on their experiences. For example, participant 2 stated, “I think that doing physical holds can bring up some triggers or trauma responses, but if done properly then they can be helpful in order to keep everyone safe.”

Participant 4 stated:

In my experience, I feel that physical holds do not cause further trauma but can re-stimulate a previous trauma. It can be more of a trigger than creating further damage. It can make it harder for some to move on from the trauma if they continue to be re-stimulated.

Participant 6 stated, “I don't necessarily think that performing holds causes' further “trauma” but I feel like it can trigger PTSD symptoms. I think physical holds trigger more trauma symptoms with adolescents whose trauma is physical or sexual abuse.”

When asked, "In your experience, when performing a physical hold on an adolescent who has been abused, have you seen negative changes in their behavior,"

Participant 2 stated:

I have seen adolescents who have dissociated, had anxiety and have had flashbacks as a result of physical holds. I have also seen adolescents who have become physically aggressive as a result and some who have self-harming tendencies seek out physical holds as a means of harming themselves.

Participant 5 stated, "I have experienced anxiety and dissociation during physical holds. There have been two incidents in regards to dissociation where the client starts "reliving" their previous trauma."

The participants identified that when performing physical holds, there is potential to cause further trauma or trigger a response to previous trauma. In order to help prevent further traumatization to the adolescents and secondary trauma to the clinicians, participants also identified the importance of processing each physical hold after it occurs.

Importance of Processing Physical Holds

In order to identify participant's feelings on re-traumatization, participants were asked, "In your experience, does performing physical holds on adolescents cause further trauma to those that already have a history of abuse?" When addressing this question, participants continued to identify the importance of processing physical holds after they occur, in order to help prevent further traumatization for the adolescent and staff member.

Participant 2 stated, "I think that a big part of this is having the adolescents know the intention of the physical holds, having a good relationship, and being able to process the situation with the adolescent afterward."

Participant 5 stated, "Depending on the client's specific trauma it can cause further trauma if done ineffectively and by not explaining reasons why performing it or by not processing it correctly afterwards."

Participant 8 stated:

I have not personally seen full dissociation, though some memory flashbacks have occurred. We are trained to check in with the youth post hold so feelings are processed to limit anxiety/withdrawal. Some become very angry due to loss of control and/or personal power. Again, processing is used to deal with that.

As seen in Participant's 8 responses above, many of the participants identified that during a physical hold, many children feel a significant loss of power or control over their own lives and bodies. Processing this with professionals is identified as a significant way to help prevent further trauma from occurring.

Loss of Power and Control

Many children with a history of abuse feel that they have no power or control over their own lives and bodies and often they have behavioral outbursts when they feel any control they do have is being taken away. In addition, participants also identified that the professionals conducting the holds may feel a lack of power or control during the hold. Throughout the interview process, participants were asked "The literature on physical holds states that if professionals were better trained on how to relate to the child or adolescent and understand their particular needs during the escalation, physical holds

could be avoided. What are your thoughts on this statement?" Participants responded to this by giving examples of their experiences. For example, Participant 5 stated, "It can feel very demeaning and scary at times because you feel you have very little control."

Participant 8 stated:

I have processed many holds. A lack of power, a fear of loss and control (both based on losing control of their behavior leading to the hold as well as being physically controlled by someone else) are common until processing can help show that holds are for safety and not power based.

In addition to triggering a trauma response in the adolescents that are experiencing the physical holds, many participants reported feeling the affects of secondary trauma from either conducting or witnessing the physical holds being performed.

Secondary Trauma

The final question asked of the participants addressed their personal experiences and reactions to witnessing or performing physical holds on adolescents with a history of abuse. Many discussed that it is never a pleasant thing and that they often wish it could be avoided all together; however participants recognized the need to ensure safety at times. In addition, some identified the potential for secondary trauma to occur after witnessing or performing such holds.

Participant 7 stated:

I remember feeling so sad for her. When she finally began crying I could hear the amount of pain she was actually in, what drove her to act the way she was. My heart honestly broke a little. It's not a funny thing, its heart wrenching.

Participant 5 stated, "It can be a difficult experience to be a part of and experience. It has caused me to work hard on creating therapeutic relationships with clients and also taking all proactive measures to avoid the need of physical holds."

Participant 3 stated:

After working 3 years at the residential treatment center, I often wonder if I caused more harm than good on these adolescents by physically restraining them. At the time, I did not think that it was traumatizing to myself but now I do believe that I too have gone through a traumatic experience by having to perform physical holds on adolescents with trauma and abuse in their background.

Participant 1 stated:

As a professional, sometimes it was traumatizing to me to have to witness and conduct these holds. I was often shocked at the experiences I have had. I witnessed things that were awful and I won't forget some of those experiences. I feel like I have experienced some things that maybe I shouldn't have had to.

Trauma or Abuse History

A major theme that was identified throughout the data addressed the likelihood of a trauma or abuse history among the adolescent populations that often experience physical holds. Participant's identified that the majority of the children or adolescents they have worked with have some type of abuse in their past or have experienced a traumatic event of some kind. Participants also identified that a history of trauma or abuse affects how the clinicians approach physical holds with this population. It was also reported that these abusive or traumatic experiences often replay when the child is in the physical hold and experiencing some type of trauma response. Trauma responses most

often experienced by the participants included flashbacks, dissociation or outbursts of anger. Participants reported on their experiences with this throughout the interview process. For example, participant 6 stated:

I have worked with adolescents that have experienced trauma for 7 years. I interned as a juvenile probation officer for 9 months and many of the kids on my caseload for probation had experienced trauma. Many of the adolescents I work with now have experienced trauma of some sort.

Participant 3 spoke about reflecting upon how effective physical holds might be and stated, “I’ve thought about it more and wondering how effective we were being to their health and treatment by physically restraining them when they had previous abuse and trauma.”

Participant 7 stated, “The majority of the population [in residential treatment] has gone through abuse or trauma in some form. Sometimes I feel like that’s been my life.”

Participant 8 stated:

I have worked at a non-profit residential treatment facility whose population is adolescents with mental health and behavioral issues for 16 years. The more we learn about trauma, the clearer it becomes that pretty much all of our population has experienced traumatic things, though they may not express it as such.

When discussing how to approach adolescents with a history of abuse and the importance of utilizing other techniques when possible, participants indicated that knowing a child’s abuse history can help with this. For example, Participant 4 stated:

Knowing a child’s history of abuse may cause me to try to postpone the physical hold as long as I can. But, doing a physical hold, for me, is when the child is no

longer safe to themselves or others and not just because they are doing negative behavior.

Participant 8 also stated:

I was given educational training and hands on “how to” based on approved procedures. More recently we are improving training to include more information on the trauma aspects of holds, both to the client and potentially the staff involved as well.

In conclusion, the eight participants provided information on the following themes: ensuring safety, importance of training, client specific trauma response, importance of processing physical holds, loss of power and control, secondary trauma and trauma or abuse history. The themes identified by these participants provided data on the effects of physical holds on adolescents with a history of abuse. The data reflects the importance of ensuring safety for this population through the use of physical holds if needed, as well as the importance of adequate training for professionals. The data identifies that there is potential for physical holds to trigger a trauma response in this adolescent population and stresses the importance of processing physical holds after each incident. The data collected will assist in answering the research questions posed at the beginning of this study as well as provide valuable information for clinicians working with this population.

Discussion

The following research questions were examined for this project; 1) What are the experiences of clinicians in witnessing and performing physical holds on children with a history of abuse? and 2) What is the clinician's perception of how this adolescent

population is affected by physical holds? The findings from this research project indicate that clinicians feel performing physical holds on adolescents with a history of abuse is not a preferable practice and has the potential to cause further trauma to these individuals. However, most often physical holds are done for safety purposes only and often cannot be avoided. Clinician's indicated that they felt adequate training, being able to understand and relate to the adolescents who may be placed in the physical holds and performing physical holds only when absolutely necessary for safety purposes are vital components to preventing unnecessary trauma or harm to these individuals.

Specific themes found within this research project included, a) Ensuring Safety, b) Importance of Training, c) Client Specific Trauma Response, d) Importance of Processing Physical Holds, e) Loss of Power and Control, f) Secondary Trauma and g) Trauma or Abuse History.

Controversies Surrounding Physical Holds

The literature review highlighted physical holds as an ongoing controversy with professionals. Even though there are many negative aspects to physical holds, professionals have also identified the need to conduct these holds for safety purposes. In addition, some clinicians believe that physical holds allow children to see that adults are able to keep them safe and control the environment around them, as well as provide them with a type of therapeutic physical touch (Zeigler, 2004). The data collected in this study confirms that many clinicians feel that physical holds are necessary at times to ensure safety for the child or those around them. However, clinicians also spoke about wanting to reduce the frequency of holds as much as possible.

According to Lorraine Fox (2004), "One way to reduce the amount of physical restraints in a treatment program is to encourage staff to view restraint from the client's point of view (p.1)." Participants were asked about this in the interview and many agreed with this statement, reporting that if professionals attempt to understand what the client is experiencing, they may be more likely to de-escalate the adolescent before the hold occurs. That being said, when commenting on this statement, clinicians also made it clear that despite professionals' ability to empathize with the child or adolescent, there are still times when holds would be necessary based on safety alone.

Positive and Negative Effects of Physical Holds

In terms of the effects of physical hold, the majority of the research studies explored in the literature review focused on the negative effects of holds including death, re-traumatization, and physical injuries (Bullard et. al., 2003; Nunno et. al, 2006 & Fox ,2004). Similarities found in this study include concerns surrounding possible re-traumatization or a potential for trauma response to be triggered by the physical hold. However, none of the clinicians spoke about the possibility of physical injuries or death related to physical holds. Throughout the data, clinicians identified the possibility for the adolescent to experience a "trauma response" as well as potential secondary trauma to the professionals involved. The clinicians also identified the importance of ensuring safety for all involved when choosing to conduct a hold.

Trauma Response. One of the most apparent negative effects indicated by the participants is the possibility of the adolescent experiencing a trauma response during the physical hold. Dave Zeigler (2004) found that children who have been physically or sexually abused in the past may experience re-traumatization of some kind from physical

holds. Being that the adolescents were not part of this study, it was not determined in this study if actual re-traumatization occurs during physical holds. However, the majority of the participants in this study commented that they believe some type of trauma response is triggered by a physical hold. Dyregrov & Yule, (2006) found that many things can trigger a flashback or physical symptoms that are associated with the abuse they experienced. Similar to this study, participants discussed physical symptoms that occur during the physical holds that may be associated with the abuse they previously experienced.

In addition, author Lorraine Fox (2004) also refers to four stress responses that can occur when a child is re-experiencing their trauma: “intense fear, helplessness, horror, and mental disorganization (p.3).” Participants in this study specifically discussed witnessing dissociation, flashbacks, angry outburst or aggression, crying and the intense fear or helplessness that Lorraine Fox refers to in the previous study. Participants reported that each child’s response was different given the situation; however the participants reported that the majority of adolescents placed in holds experience some type of “trauma response” to the hold.

Secondary Trauma. Authors Steckley and Kendrick (2008), state that many staff struggle with “overriding emotions of guilt, doubt or defeat at not being able to avoid the physical restraint (p.562).” This study also addressed the potential for secondary trauma to occur when witnessing or conducting physical holds. The majority of participants in this study specifically indicated feeling they may have been “traumatized” or experienced secondary trauma from conducting physical holds or from the adolescent experiencing a significant response to a physical hold. As previously

stated, participants indicated that they witnessed or experienced things that were shocking and they will likely have trouble forgetting those situations.

This study found similarities with other studies indicating that professionals often have a significant emotional experience to the physical hold and feelings of guilt or regret over conducting the physical holds. One previous study indicated staff members' had different reactions to the restraint experience. Staff members from this study indicated that experiencing restraints was horrific, discouraging, or full of guilt (Steckley and Kendrick, 2008). As stated previously, a participant from this study indicated she had a significant emotional response when conducting a physical hold on an adolescent that had a substantial trauma response to the hold.

Ensuring Safety. Safety was a recurring theme found in this study. Participants indicated that safety was the most common purpose for initiating physical holds. Previous studies have also indicated that overall safety for this population is most important and physical restraint is the surest way to prevent injury or significant harm (Zeigler, 2004). The participants of this study indicated that ensuring safety for the adolescent as well as bystanders as a very important thing to consider. Participants stated that many times this population engages in behaviors that put themselves or others at risk and this is when a physical hold becomes absolutely necessary.

Alternative Techniques and Importance of Training

Training. Author Lorraine Fox (2004) reports that clinicians who are in charge of doing physical holds on children may not be adequately trained on how or when a physical hold is appropriate. Professionals may not be trained on the right techniques in order to complete a hold safely according to each child's personal needs. This study

found opposing information as the majority of the participants felt that the training they were given was adequate and appropriate. Participants reported that they felt the training they received before conducting holds was “hands on” and helped them to better understand what the child might be experiencing when in the hold. Participants also identified having continued training every 6 months to a year which participants reported helped ensure their training was adequate.

One study indicates that greater staff competency is linked to fewer injuries as a result of physical holds (Bullard et. al, 2003). Participants of this study indicated that they also felt that the training they received was thorough and ensured that they felt comfortable conducting holds without causing harm to the child. A few participants also indicated that they were trained to look for signs that may indicate that a child is in some type of physical distress.

Processing of the Holds. Throughout this study, the majority of participants continued to indicate the importance of processing the physical hold with the adolescent after the hold occurs. Participants indicated this is crucial to ensure that the child understands why the hold was conducted as well as allows time talk about any feelings they may have experienced during the hold. As stated above, participants indicated that they felt they had been adequately trained on how to process with the youth after the hold to help limit anxiety or feelings of loss of power or control. Previous research does not address the idea of processing the hold with the child after it is conducted, instead focuses on alternative techniques to be utilized ahead of time in hopes of preventing the hold all together.

In one study, Bullard et. al (2003) indicates de-escalation techniques that can be used instead of physical holds including: prompting, using active listening, problem solving, conflict resolution, redirection, and directive statements, among many others. Though the participants of this study did address the use of de-escalation techniques in hopes of preventing a physical hold, participants strongly indicated that avoiding physical holds all together is not probable. Therefore, the importance of processing each hold afterwards becomes even more apparent. This finding was not specifically addressed in previous research and may indicate an area where further studies would be beneficial.

Strengths & Limitations

This study offers several strengths. First, the questions being asked were formed directly from the literature and the researchers experience with physical holds. The questions were intending to gain first-hand experience from the clinicians being interviewed. This study helped to support current social work practices by identifying areas of strength as well as other areas that may need to be improved upon. This study was explored from the perspective of those clinicians currently working with the population being studied. It has addressed the lack of current research on this topic as well as the lack of research from a clinician's perspective. Last, this study was conducted in a qualitative manner, therefore designed to provide a more comprehensive and detailed account of the clinicians' experiences.

This study also has a few limitations. First, it was conducted within a short time period and with a small sample size. This study also relied on the availability of the participants. Second, the participants were only asked 10 questions during the interview process, again due to the time constraints of the project. Last, the participants were all

selected from agencies that are within the same larger company and no participants from other companies were pursued. Therefore, the sample only offered limited diversity in respect to various agency perspectives. In spite of these limitations, this study is still relevant and important to the social work field.

Implications for Social Work Practice

Given the information and knowledge gathered from the literature review and the findings of this study, physical holds remain a practice that is at times necessary to ensure the safety of adolescents. However, clinicians and children are still at risk for experiencing trauma responses related to the physical hold. Social workers can assist in helping to prevent this by ensuring they are vigilant in processing the physical holds after they occur. Processing should occur not only with the child but as a professional team as well, to ensure that secondary trauma is not occurring within the professional staff members. It is important for professionals and family members of these children to understand the need for physical holds as well as the potential effects of these holds so that the appropriate steps can be taken to reduce the effects as much as possible.

Social workers and other professionals working in settings where these holds occur can help by educating family members, other professional staff and the children about the reasons for physical holds and how to handle the processing of the hold after it occurs. Social workers can also assist in making sure that all staff that will be witnessing or conducting these holds is properly trained and that adequate training is provided on a quarterly or annual basis.

This research shows the importance of ensuring that as social work professionals, we are continuing to be aware of the implications physical holds may be having on this

population. It is important that the clinicians feel they are adequately trained, have support and are able to process each situation in hoping of preventing burnout or secondary trauma. It is also important that the social work profession continues to stay informed on the latest research and practice guidelines for conducting physical holds, as well as potential alternative methods that may arise in hopes of preventing further harm and trauma to these adolescents.

Implications for Policy

In addition to on-going education and research for the social work profession, there needs to be additional mental health resources for children and adolescents to help ensure they are receiving the most appropriate care and treatment. The more opportunities we can provide these children and their families for treatment, the less likely it is that one of these children will be in a situation where they will need to be placed in a physical hold.

As social work professionals, we need to advocate for our clients to ensure that there are enough resources for them to access and that these children are receiving all the treatment they need for mental health and behavioral disorders. We can also advocate for further education seminars and training programs for all professionals working in the mental health field so they are aware of the implications this practice may have on the children as well as the potential affects to the professionals. It is important that we include opportunities to learn about this as part of social work continuing education. Social workers can also act as advocates for other professions to continue to learn about physical holds. This information would likely be helpful to a broad range of professionals including teachers, support staff, police officers, doctors and any other professionals that

may be working in school, hospital, residential or other mental health settings and interacting with children who experience significant behavioral disturbances.

Implication for Research

Further research on this topic should focus on the importance of processing physical holds after they are conducted and the best practices available to effectively conduct this with children and adolescents. This may help to reduce some of the re-traumatization or trauma responses that children and adolescents may have from the physical holds and may even help clinicians determine how to use the physical hold experience to help the child grow. Throughout previous research as well as this study, it was determined that physical holds may not only have effects on the child or adolescent in the hold but there is potential for significant effects on the staff performing the holds as well as the bystanders who witnessed the hold. It would be beneficial to have further research on the potential secondary trauma effects of physical holds on professionals and methods in which clinicians can work to help avoid this.

Further studies that may be beneficial to professionals is to conduct research from the point of view of the child or adolescent to determine what reactions they may be having to the physical holds and how professionals may be able to help eliminate or reduce any negative emotions or responses that occur for these children.

Conclusion

While there are some definite adverse effects that arise from conducting physical holds on adolescents with a history of abuse, it appears that the frequency in the use of physical holds is gradually being reduced in hopes of using this intervention for safety purposes only. However, in addition to some of the adverse effects that may occur from

these holds, there is also the potential for positive outcomes, mainly the safety of the adolescent that may be experiencing an extreme behavioral outburst or those around them at the time of the incident. Physical holds also have the potential to be utilized as a therapeutic tool to help adolescents learn to manage their behavior more appropriately and improve their ability to interact with others if they are processed thoroughly with professionals after they occur.

With additional support from policy makers, further research and continuing education, it is possible that the social work profession can help significantly reduce the negative effects associated with physical holds. In addition, professionals have the potential to learn to use holds as a therapeutic tool rather than a dangerous or traumatizing intervention.

References

- American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: Author.
- Berg, B. L. *Qualitative Research Methods for the Social Sciences*. (8th ed., pp. 1-420). Pearson Education, Inc.
- Bullard, L., Fulmore, D., & Johnson, K. (2003). Reducing the use of restraint and seclusion. *Child Welfare League of America*, 4(3), 1-5. Retrieved from [http://centerforchildwelfare2.fmhi.usf.edu/kb/mentalhealth/Achieving%20Better%20Outcomes%20\(CWLA\).pdf](http://centerforchildwelfare2.fmhi.usf.edu/kb/mentalhealth/Achieving%20Better%20Outcomes%20(CWLA).pdf).
- Couvillon, M., Peterson, R., Joseph, R., Schauermaun, B., & Stegall, J. (2010). A review of crisis intervention training programs for school. *TEACHING exceptional Children*, 42(5), 6-17. Retrieved from <http://www.maine.gov/education/rulechanges/chapter33/022411dbutlercitreviewofrestraintsinschoolsinschools.pdf>.
- Crosland, K. A., Cigales, M., Dunlap, G., Neff, B., Clark, H. B., Giddings, T., et al. (2008). Using staff training to decrease the use of restrictive procedures at two facilities for foster care children. *Research on Social Work Practice*, 18(5), 401-409. doi:10.1177/1049731507314006
- Day, D. (2002). Examining the therapeutic utility of restraints and seclusion with children and youth: The role of theory and research in practice. *American Journal*, 72(2), 266-278. doi: 10.1037/0002-9432.72.2.266
- Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child & Adolescent Mental Health*, 11(4), 176-184. doi: 10.1111/j.1475-3588.2005.00384

- English, K. A. (2005). Factors affecting length of stay in residential treatment for children with serious emotional disturbance, 115-135. Retrieved from:
<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=76604&site=ehost-live>
- Fox, L. E. (2004). The impact of restraint on sexually abused children and youth. *Child Welfare League of America*, 4(3), 1-5.
- Frueh, C. B., Knapp, R. G, Cusack, K. J., Grubaugh, A. L, Sauvageot, J. A., Cousins, V.C., . . . Funsil, Y. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, 56(9) doi: 10.1176/appi.ps.56.9.1123
- Gallop, R., & McCay, E. (1999). The experience of hospitalization and restraint of women who have a history of childhood sexual Abuse. *Health Care For Women International*, 20(4), 401-416. doi: 10.1080/073993399245683
- Hammer, J. H., Springer, J., Beck, N. C., Menditto, A., & Coleman, J. (2011). The relationship between seclusion and restraint use and childhood abuse among psychiatric inpatients. *Journal of Interpersonal Violence*, 26(3), 567-579.
doi:10.1177/0886260510363419
- Hesse, E & Main, M. (2000). Disorganized Infant, Child and Adult Attachment: Collapse in Behavioral and Attentional Strategies. *Journal of the American Psychoanalytic Association*. 48(4), 1097-1127.
- Jones, R. J., & Timbers, G. D. (2003). Minimizing the need for physical restraint and seclusion in residential youth care through skill-based treatment programming. *Families in Society*, 84(1), 21-29. Retrieved from:<http://search.proquest.com.ezproxy>.

stthomas.edu/docview/61334391?accountid=14756.

- Kendrick, A., Steckley, L., & Lerpiniere, J. (2008). Ethical issues, research and vulnerability: Gaining the views of children and young people in residential care. *Children's Geographies*, 6(1), 79-93. doi:10.1080/14733280701791967
- Leighninger, R. D. (1977). Systems theory and social work: A reexamination. *Journal of Education for Social Work*, 13(3), 44-49. doi: 10.1080/00220612.1977.10671455
- Mercer, J. (2002). Child psychotherapy involving physical restraint: Techniques used in four approaches. *Child & Adolescent Social Work Journal*, 19(4), 303-314.
Doi:10.1023/A:1016353812731
- Mullen, J. K. (2000). The physical restraint controversy. *Reclaiming Children and Youth: Journal of Emotional and Behavioral Problems*, 9(2), 92-94, 124. Retrieved from <http://search.proquest.com.ezproxy.stthomas.edu/docview/61469041?accountid=1475>
- Nunno, M. A., Holden, M. J., & Leidy, B. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility. *Children and Youth Services Review*, 25(4), 295-315. Retrieved from: <http://ezproxy.stthomas.edu/login?urlhttp://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=73345&site=ehost-live>
- Nunno, M. A., Holden, M. J., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect*, 30(12), 1333-1342. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=52820&site=ehost-live>
- Pust, T. (2012) The use of prone restraint in minnesota schools: August 2011 through January 2012. Retrieved from: <http://education.state.mn.us/mde/mdeprod/>

- groups/educ/documents/basic/041371.pdf
- Siegel, D. (1999). *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are*. New York, Guilford Press. Pp. 141-168.
- Smith, M. L., & Bowman, K. (2009). The restraining spiral: Emergent themes in the perceptions of the physical restraint of juveniles. *Child Welfare League of America*, 88(3), 57-61.
- Steckley, L. (2012). Touch, physical restraint and therapeutic containment in residential child care. *The British Journal of Social Work*, 42(3), 537-555. doi: 10.1093/069
- Steckley, L. (2010). Containment and holding environments: Understanding and reducing physical restraint in residential child care. *Children and Youth Services Review*, 32(1), 120-128. Doi: 10.1080/17496535.2011.571068
- Steckley, L., & Kendrick, A. (2008). Physical restraint in residential childcare: The experiences of young people and residential workers. *Childhood*, 15(4), 552-569. doi:10.1177/0907568208097207
- Ziegler, D. (2004). The therapeutic value of using physical intervention to address violent behavior in children. *Child Welfare League of America's Children's Voice*, 13(4). .

Appendix A

Interview Questions

Overall Question: What is your experience in witnessing and performing physical holds on adolescents with a history of abuse? What is your perception of how this adolescent population is affected by physical holds?

- 1) What is your overall experience with adolescents who have experienced abuse or trauma?
- 2) What is your experience in performing physical holds on children or adolescents?
- 3) How much and what kind of training or education were you given on how to perform physical holds?
- 4) Do you feel you have been given adequate training on how to perform physical holds on children or adolescents without causing harm to them? Can you describe the training you have received? What type or amount of training do you feel professionals should receive in order to accurately perform physical holds?
- 5) In your experience, does performing physical holds on adolescents cause further trauma to those that already have a history of abuse?
- 6) In your experience, when performing a physical hold on an adolescent who has been abused, have you seen negative changes in their behavior? For example, dissociation, anxiety or withdrawn? If so, can you explain what you have experienced?
- 7) What types of alternative treatment methods do you feel could be utilized to intervene with a dis-regulated adolescent that might replace the need to physically restrain them? What types of alternative interventions are used at your agency and how are they used?
- 8) Professionals have said "One way to reduce the amount of physical restraint in a treatment program is to encourage staff to view restraint from the client's point of view." How do you feel you are able to view the restraint from the point of view of the child or adolescent you are restraining? Can you describe what that looks like?
- 9) The literature on physical holds states that if professionals were better trained on how to relate to the child or adolescent and understand their particular needs

during the escalation, physical holds could be avoided. What are your thoughts on this statement?

- 10) What has your personal experience or reaction been when witnessing or performing a physical hold on an adolescent with a history of abuse? What impact has this experience had on you as a professional?

Appendix B

Email Script/Information Sheet

To whom it may concern,

My name is Keeli Wagner and I am a Masters of Clinical Social Work student under the direction of Professor Catherine Marrs Fuchsel, PhD in the School of Social Work at St. Catherine University and the University of St. Thomas. I am conducting a research study to explore the experiences of social work professionals that have experience performing or witnessing physical holds on adolescents with a history of abuse. I am interested in learning their perspective on how physical holds affect adolescents who have a history of abuse and if there may be alternative methods that can be utilized in these psychiatric settings. I hope that my experiences with this study will help other social work professionals understand the impact of physical holds on adolescents with a history of abuse.

I am currently recruiting participants that are working in a setting in which they may have experience performing or witnessing physical hold interventions on adolescents with a history of abuse. I am very interested in your involvement in this study, as you have been identified as a professional that has related experience. Your participation in this study would involve an interview either in person, over the phone or through secure email. The interview will last approximately one hour. In- person interviews will be audio-taped and written interviews will be kept and documented, all with your permission. I will be conducting the interview at a public or semi-public location preferred by the participant, that has a closed and private space. The interviews will be scheduled based on the participant's schedule and what works best for him/her. If you are willing to participate, I will provide you with the interview questions to review and will ask that you sign a consent form prior to the interview. If you have any questions, those will be addressed before you take part in the interview as well.

This study is voluntary and you may withdraw from the study at any time. If you choose not to participate, it will not affect you in anyway. You may also choose not to answer any of the interview questions. In the interview, you will be asked about your experience with the stated population and how you feel physical holds affect

professionals as well as the adolescents experiencing the hold. You will also be asked about the training you have received in conducting physical holds and if you feel this training has been adequate for you to complete these holds affectively. Participants will be asked their professional opinion on alternative interventions and treatment methods that might be used with this population.

The information in this study will be published in my clinical research paper and may be published in social science journals. Your name will not be used to identify you and all recordings or transcripts will be kept in a locked, confidential place that only I have access to. The data will be kept until the research is completed and published and it will then be destroyed.

If you have any questions about your rights as a participant in this study or you feel you have been placed at risk, please contact the chair of Human Subjects Institutional Review Board, John Schmitt through St. Catherine University at 651-690-7739.

Please respond if you are interested and willing to participate in my research study. Your involvement would be greatly appreciated.

I can be reached by email at xxxxxxxx@xxxxxxxx.xxx or phone at xxx-xxx-xxxx.

Thank you very much for your time,

Keeli Wagner, LSW

Appendix C

CONSENT FORM

Physical Holds in Adolescents with a History of Abuse

I am conducting a study about the experiences of professionals who have witnessed or performed physical holds on adolescents who have a history of abuse. I invite you to participate in this research. You were selected as a possible participant due to your knowledge and experience with adolescents who have experienced abuse and conducting physical holds. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Keeli Wagner, a graduate student at the St. Catherine University and University of St. Thomas School of Social Work and supervised by Dr. Catherine Marrs Fuchsel, a faculty member at the school.

Background Information:

The purpose of this study is to determine the affects of conducting physical holds on adolescents who have a history of abuse. This information will be analyzed so that it might better serve social work professionals working in this field.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participate in an in person, email or phone interview that will be no more than one hour long. This interview will be audio taped for transcription purposes and the information will be analyzed and presented in my research presentation. My faculty advisor, Catherine Marrs Fuchsel, PhD., LICSW will be reviewing my data as well.

Risks and Benefits of Being in the Study:

There are minimal risks to this study including potential emotional disturbance of the participants.

This study may have general benefits for other social workers in practice.

Confidentiality:

The records of this study will be kept confidential. Research records will be kept in a locked file at the researcher's residence. I will also keep the electronic copy of the transcript in a password protected file on my computer. My research advisor will be reviewing my data, but will not know who you are. I will delete any identifying information from the transcripts. All of my documentation and audio-tapes will be destroyed upon completion of this research project.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

Contacts and Questions

My name is Keeli Wagner. You may ask any questions you have now. If you have questions later, you may contact me at xxx-xxx-xxxx or my faculty research advisor, Dr. Catherine Marrs Fuchsel via email at clmarrsfuchsel@stkate.edu. You may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board at (651) 690-7739 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix D

Phone Script

Hi, my name is Keeli Wagner and I am a Masters of Clinical Social Work student at St. Catherine University and the University of St. Thomas. I am conducting a research study to explore the experiences of social work professionals that have experience performing or witnessing physical holds on adolescents with a history of abuse.

I am currently recruiting participants that are working in a setting in which they may have experience performing or witnessing physical hold interventions on adolescents with a history of abuse. I am very interested in your involvement in this study, as you have been identified as a professional that has related experience. Your participation in this study would involve an interview either in person, over the phone or through secure email. The interview will last approximately one hour and will be done to protect your confidentiality.

If you are able and willing to participate in my study, I can send you an informational sheet that will provide you with further details on what is involved in the study and how your involvement will be utilized.

Thank you very much for your time,

Keeli Wagner

Appendix E**Letter of Cooperation for Research Project**

Institutional Review Board
St. Catherine University
St. Paul Campus
2004 Randolph Avenue
St. Paul, MN. 55105

RE: Exploratory evaluation of professionals' experiences in witnessing and performing physical holds on children with a history of abuse.

Lead Investigator: Keeli Wagner, LSW
Graduate Student
Catherine L. Marrs Fuchsel, PhD., LICSW
Faculty Advisor
St. Catherine University and the University of St. Thomas
School of Social Work; Joint Program

To whom it may concern:

We have agreed to assist Keeli Wagner in recruiting participants for her research project. Keeli's research project will be an exploratory evaluation of a clinicians experience in witnessing and performing physical holds on adolescents with a history of abuse. The experience will be documented through interviews with clinicians who have witnessed or performed physical holds. We will allow Keeli access to clinicians within our agency through phone contact, email recruitment or informational flyer recruitment, who have experience in this area and will allow her to interview these clinicians on this area of research.

These interviews will be documented and audio taped, however no person will have access to these audiotapes except for Keeli Wagner and her advisor, Catherine Marrs Fuchsel. These documents will be immediately destroyed after completion of the research project.

Keeli will make it clear to potential participants that they are free to refuse to participate in her research project and that this will not affect their relationship with any our agency in any way. Upon completion of this research project, Keeli will share the findings of this research project with our agency if interested. If you have any questions, please feel free to contact me at xxx-xxx-xxxx.

Sincerely,

Signature and Title
Print Name

Date
Date

Appendix F**Mental Health Resource Handout****Mental Health Crisis Response:**

Anoka County- 763-755-3801

Ramsey County- 651-266-7900

Hennepin County- 612-596-1223

Washington County- 651-777-5222

Area Counseling Resources:**Ramsey County Mental Health:**

1919 University Ave W

St Paul, MN 55104

(651) 266-7999

Nystrom & Associates

1900 Silver Lake Road, Suite 110

New Brighton, MN 55112

(651) 628-9566

1181 Weir Drive, Suite 270

Woodbury, MN 55125

(651) 714-9646

Family Innovations, Inc

(Locations in Alexandria, Anoka, Centerville, Eden Prairie, Hudson, Stillwater, Maplewood and home based support)

Anoka Location (Main office)

1833 3rd Avenue

Anoka, MN 55303

763-421-5535

Appendix G*Figure 1.1 Prone Hold*

Figure 1.1 Prone Hold: The child's arms and legs are held by at least two adults while child lies on his/her front in a face-down or face-to-the-side position. Adapted from Pust, T. (2012) "The Use of Prone Restraint in Minnesota Schools: August 2011 through January 2012," by Tammy Pust and Minnesota Department of Education, 2012. FY 2012 report to the legislature.

Figure 1.2 Basket Hold



Figure 1.2 Basket Hold: An adult holds a child from behind by the wrists with the child's arms crossed in front of the child; this can be done sitting, standing or lying down
Adapted from Pust, T. (2012) "The Use of Prone Restraint in Minnesota Schools: August 2011 through January 2012," by Tammy Pust and Minnesota Department of Education, 2012. FY 2012 report to the legislature.

Figure 1.3 Supine Hold

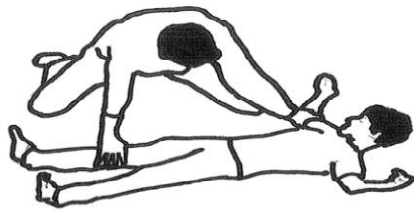


Figure 1.3 Supine Hold: The child's arms and legs are held by at least two adults while child lies on his/her back Adapted from Pust, T. (2012) "The Use of Prone Restraint in Minnesota Schools: August 2011 through January 2012," by Tammy Pust and Minnesota Department of Education, 2012. FY 2012 report to the legislature.